OBSTETRICS & GYNECOLOGY

NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*

**The corresponding author has opted to make this information publicly available.*

Personal or nonessential information may be redacted at the editor's discretion.

Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office: obgyn@greenjournal.org.

Date: May 01, 2020
To: "Ayisha Buckley" abb08c@gmail.com
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-1015

RE: Manuscript Number ONG-20-1015

Universal testing of patients and their support persons for COVID-19 prior to scheduled deliveries within the Mount Sinai Health System: A look at the prevalence of infection and concordance/discordance rates

Dear Dr. Buckley:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Dr. Chescheir is interested in potentially publishing your revised manuscript in a timely manner. In order to have this considered quickly, we need to have your revision documents submitted to us as soon as you are able. I am tentatively setting your due date to May 4, 2020, but please let me know if you need additional time.

The standard revision letter text follows.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

REVIEWER COMMENTS:

Reviewer #1: I think this overall is important information. I think, though, that the manuscript is much too long and should be condensed into a research letter.

1) The interesting part of your work is the snapshot in time of a) asymptomatic infection frequency; 2) partner positivity frequency, and 3) concordance. All of this could be much more succinctly stated;

2) The baby piece is also interesting but needn't be belabored;

3) To get to a shorter length, the management aspects could be greatly condensed;

4) Throughout you refer to an "infectious screening tool" which means literally that the tool itself is capable of causing infection. I think you mean "infection" screening tool;

5) It is not clear to me what your test detects- RNA orwhole virus. If not the latter, could the positives not actually been infected but recovered with evidence of recent infection?

Reviewer #2: The authors conducted a cohort study on a timely topic as all L&D units are struggling with how to mitigate risks of COVID-19 yet facilitate social supports during the pandemic. The findings are of interest, yet given this data is from an epicenter, it would not necessarily be broadly applicable as the rates would be expected to vary wildly across the country and at any one point in time.

Intro
1 - How does this study differ from citation #5?
2 - It appears that only planned c-sections and IOL patients were tested. What about all of the other patients and their support person who were admitted during this time-frame?
3 - One wonders what is the utility of the screening phone call? Is this even necessary?

Methods
4 - How long did it take to get the result (Line 138 and 148)?
5 - It has the impression that COVID-positive patients and perhaps their positive partners walked through the hospital

without a mask until arriving at L&D were they were issued one to wear (Line 154)?
6 - What was done with the newborns from a COVID-positive mother?

Results
7 - 3 patients refused screening (line 178)?
8 - Unclear what is meant by 'presumptive positive' (line 185) - were they symptomatic, or was the test equivocal?
9 - Did Sinai have any policy about the number of allowed support persons during this interval? Line 187 states that 4 pts had a secondary support person - was this a second person in the room, or does this mean support person #1 tested positive and this person stepped in, instead?

Discussion
10 - Unclear what is being said lines 218-222. Earlier it was stated all the support persons were asymptomatic, but here is said 'they were already symptomatic'?
11 - The authors provide some general statements in paragraph lines 234-244, but what is Sinai doing? Do they have a separate unit for COVID-positive patients postpartum? What are they doing with the newborns?
12 - Also unclear what is being stated in lines 245-248. Sounds unnecessarily repetitive. Are they saying that if/when 'rapid/reliable' POC testing becomes available it would/could replace what they are doing now? It would be clearer to say this is the best strategy we have at the moment because we don't have such a test.
13 - The emphasis on anxiety (line 249) feels overdone. If patient and support both test negative, are they not wearing masks? Are the health care providers wearing masks in these rooms?
14 - What basis do the authors have for suggesting that universal testing 'may result in improved outcomes' (line 260)?

Figures
15 - Fig 1 does not seem necessary and could be shifted to Appendix or Supplementary Data
16 - Fig 2 also is not easy to understand and unnecessary to this reviewer

Tables
17 - This reviewer does not understand the value of Table 1 when 0 patients/support persons screened positive
18 - Table 2 also is entirely provided in the text - and this seems repetitive

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

lines 60-62: Should include include CIs for the prevalence rates among patients 15.5% (9.9-23.0%) and support persons 9.6% (5.2-16.1%)

line 62 and Table 2, row labelled "Positive": The 11/19 and 8/19 fractions should be rounded to nearest integer %, not cited to 0.1% precision, due to the small denominator.

lines 65-68: Wouldn't a better characterization be to first state the rate of (+) COVID-19 and that all were asymptomatic in terms of the questionnaire used at the time and secondarily then report the rate of (+) among support persons? After all, all were asymptomatic.

General: These women and their support persons were in hospital from April 4-15. Is there follow-up to determine whether the asymptomatic were actually pre-symptomatic, that is, did they subsequently develop symptoms?

General: While the agreement between patients vs partners in terms of their COVID-19 test status was far from perfect, it was certainly not randomly allocated. By Fisher's test, the distribution is quite significant ($p < .0001$), while in terms of Kappa test for concordance, the value was $k = 0.63$ (95% CI = 0.42-0.83), which is classified in the moderate to good range for concordance. Again, it is not perfect, but it is also not discordant, in which the K value would be negative. Put another way, just looking at Fig 2, most patients who were (-) had partners who were (-), while among 19 (+), 8 had partners who were also (+), ie, clearly not a random allocation of test results. The CIs on the fraction 11/19 are quite wide, owing to the small sample, namely 58% (95% CI = 29-100%), making it difficult to generalize from these data that > 50% of partners of women who were (+) would be negative. Need more data to make a definitive statement re: rates of concordance for patient/partner pairs.

Although a small number of (+), it would be informative to include a Table of age, parity etc for the 24 (+) vs the remaining 131 (-) women. Were there any important differences in terms of age, children in the home etc?

MANUSCRIPT EDITOR:

1. The title is quite long. I suggest changing it to, “Universal Testing of Patients and Their Support Persons for

Coronavirus Disease 2019 (COVID-19) Prior to Scheduled Deliveries: Prevalence of Infection and Concordance and Discordance Rates."

2. The running title should be shortened to about 45 characters. If "COVID-19" is at the beginning of the running title, it will need to be spelled out.

3. Spell out the virgule in "concordance/discordance."

The appendix seems awfully small to make it an appendix. Can we make it a box?

EDITOR'S COMMENTS:

We no longer require that authors adhere to the Green Journal format with the first submission of their papers. However, any revisions must do so. I strongly encourage you to read the instructions for authors (the general bits as well as those specific to the feature-type you are submitting). The instructions provide guidance regarding formatting, word and reference limits, authorship issues and other relevant topics. Adherence to these requirements with your revision will avoid delays during the revision process by avoiding re-revisions on your part in order to comply with formatting.

Numbers below refer to line numbers.

52.Please note that your study was conducted from date 1 to date 2, not between those dates. As written, it would exclude the dates given.

59. You don't need to state this as it is in your methods.

98. Please provide latest figures with revision

136: please clarify. The symptom screen was on the phone. If they screened negative, did they have to come in the day before for NP Swab or was that done on admission? Do you know the test characteristics of your lab test? (FP, FN/Sens /Spec?)

148: what was turn around time?

150: if the support person was designated as a PUI were they allowed to attend the birth?

151: perhaps "birth partners" or "Labor support person" or something as 'partners" typically refers to relationship partners.

190: Unless there is a 3rd option for result (indeterminate?) you don't need to give both the positive and negative rate, as they should be inverse of each other.

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
A. OPT-IN: Yes, please publish my point-by-point response letter.
B. OPT-OUT: No, please do not publish my point-by-point response letter.

2. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

3. All studies should follow the principles set forth in the Helsinki Declaration of 1975, as revised in 2013, and manuscripts should be approved by the necessary authority before submission. Applicable original research studies should be reviewed by an institutional review board (IRB) or ethics committee. This review should be documented in your cover letter as well

in the Methods section of the body text, with an explanation if the study was considered exempt. If your research is based on a publicly available data set approved by your IRB for exemption, please provide documentation of this in your cover letter by submitting the URL of the IRB website outlining the exempt data sets or a letter from a representative of the IRB. In addition, insert a sentence in the Methods section stating that the study was approved or exempt from approval. In all cases, the complete name of the IRB should be provided in the manuscript.

4. All submissions that are considered for potential publication are run through CrossCheck for originality. The following lines of text match too closely to previously published works.

Please cite lines 142-144 [A false negative…in the specimen]; our software shows that this is from Gnomegen's COVID-19 instructions for use.

5. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), observational studies using ICD-10 data (ie, RECORD), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at http://ong.editorialmanager.com. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, RECORD, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

6. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

7. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

8. Titles in Obstetrics & Gynecology are limited to 100 characters (including spaces). Do not structure the title as a declarative statement or a question. Introductory phrases such as "A study of..." or "Comprehensive investigations into..." or "A discussion of..." should be avoided in titles. Abbreviations, jargon, trade names, formulas, and obsolete terminology also should not be used in the title. Titles should include "A Randomized Controlled Trial," "A Meta-Analysis," or "A Systematic Review," as appropriate, in a subtitle. Otherwise, do not specify the type of manuscript in the title.

9. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:

* All financial support of the study must be acknowledged.
* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.
* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

10. Provide a short title of no more than 45 characters, including spaces, for use as a running foot.

11. Provide a précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words that states the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."

12. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you

submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limit for Original Research articles is 300 words. Please provide a word count.

13. Only standard abbreviations and acronyms are allowed. A selected list is available online at http://edmgr.ovid.com/ong/accounts/abbreviations.pdf. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

14. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

15. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.

16. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%").

17. We discourage claims of first reports since they are often difficult to prove. How do you know this is the first report? If this is based on a systematic search of the literature, that search should be described in the text (search engine, search terms, date range of search, and languages encompassed by the search). If it is not based on a systematic search but only on your level of awareness, it is not a claim we permit.

18. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

19. Figures 1-2: Please upload as figure files on Editorial Manager.

20. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at http://edmgr.ovid.com/acd/accounts/ifauth.htm.

Please note that if your article is accepted, you will receive an email from the editorial office asking you to choose a publication route (traditional or open access). Please keep an eye out for that future email and be sure to respond to it promptly.

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If you choose to revise your manuscript, please submit your revision through Editorial Manager at http://ong.editorialmanager.com. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:

* A confirmation that you have read the Instructions for Authors (http://edmgr.ovid.com/ong/accounts/authors.pdf), and
* A point-by-point response to each of the received comments in this letter.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors and that each author has given approval to the final form of the revision.

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief

2018 IMPACT FACTOR: 4.965

2018 IMPACT FACTOR RANKING: 7th out of 83 ob/gyn journals

Icahn School of Medicine at Mount Sinai School of Medicine
Department of Obstetrics, Gynecology, and Reproductive Medicine

~~April 20~~May 2, 2020

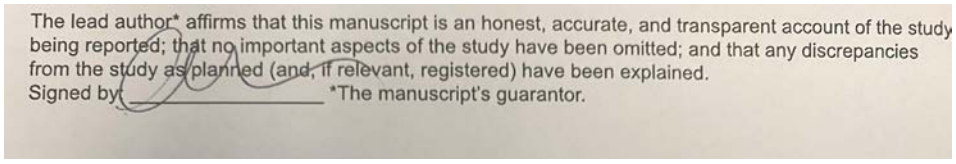
Dear Editorial Board,

We are writing to submit the attached manuscript titled: "Testing of p~~P~~atients and s~~S~~upport p~~P~~ersons for Cornonavirus Disease 2019 p~~P~~rior to s~~S~~cheduled d~~D~~eliveries~~Universal testing of patients and support persons for COVID-19 prior to scheduled deliveries within the Mount Sinai Health System: A look at the prevalence of infection and concordance/discordance rates~~". Our study material is original research, has not been previously published and has not been submitted for publication elsewhere. Our study was approved by the Institutional Review Board at Mount Sinai Hospital. The authors have no conflicts of interest. There was no written consent obtained from patients as this study was de-identified there were no descriptions of individual patients included. This study followed the STROBE guidelines and the authors reviewed the Green Journals "instructions for authors" page prior to submission. ~~We followed the STROBE guidelines.~~

This ~~study is the first study in the literature investigating~~investigates the rate of COVID 19 infection with the use of universal testing in our obstetric population presenting for scheduled deliveries as well as the concordance/discordance rate amongst their support persons. Universal testing of patients will inform obstetric and newborn care practices that may result in improved outcomes for couples, their newborns as well as health care providers.

Thank-you for your consideration.
There are no conflicts of interest to disclose.
Sincerely,

Angela Bianco, MD
Ayisha B. Buckley, MD, author, corresponding author
Jessica Overbey, DrPh, author
Brian Wagner MD, author
Cheryl Dinglas MD, author
Holly Loudon MD, author
Alan Garely MD, author
Michael Brodman MD, author
Joanne Stone, MD, author


The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.
Signed by: _____ *The manuscript's guarantor.

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REVIEWER COMMENTS:

Reviewer #1: I think this overall is important information. I think, though, that the manuscript is much too long and should be condensed into a research letter.

Respectfully we prefer to report this information as a manuscript

1) The interesting part of your work is the snapshot in time of a) asymptomatic infection frequency; 2) partner positivity frequency, and 3) concordance. All of this could be much more succinctly stated;

The manuscript has been shortened

2) The baby piece is also interesting but needn't be belabored;

This was addressed in the manuscript

3) To get to a shorter length, the management aspects could be greatly condensed;
This was addressed in the manuscript

4) Throughout you refer to an "infectious screening tool" which means literally that the tool itself is capable of causing infection. I think you mean "infection" screening tool; → ~~this was revised in the manuscript~~
This was revised in the manuscript

5) It is not clear to me what your test detects- RNA orwhole virus. If not the latter, could the positives not actually been infected but recovered with evidence of recent infection?

This is now more~~ly~~ clearly described in the Methods section. Now that we are several weeks into the pandemic we have found and it has been reported that SARS-CoV 2 RNA particles may be shed from the nasopharyngeal area for several weeks to months in these cases it is unlikely the virus is still infectious.

Reviewer #2: The authors conducted a cohort study on a timely topic as all L&D units are struggling with how to mitigate risks of COVID-19 yet facilitate social supports during the pandemic. The findings are of interest, yet given this data is from an epicenter, it would not necessarily be broadly applicable as the rates would be expected to vary wildly across the country and at any one point in time.

Intro
1 - How does this study differ from citation #5?
This study includes a larger cohort of individuals, and describes testing prior to arrival on Labor and Delivery for planned deliveries. Additionally it reports on the utility of a screening tool as well as testing of Support Persons.
2 - It appears that only planned c-sections and IOL patients were tested. What about all of the other patients and their support person who were admitted during this time-frame?
We have now included a statement that patients in spontaneous labor or with unplanned deliveries are also tested but this will be analyzed separately.

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3 - One wonders what is the utility of the screening phone call? Is this even necessary?
It corroborates the finding that infection screening tools may not be helpful but also it allowed us to instruct those Support Persons with likely COVID infection to stay home and self quarantine rather then potentially infect others.

Methods
4 - How long did it take to get the result (Line 138 and 148)? Now included
5 - It has the impression that COVID-positive patients and perhaps their positive partners walked through the hospital without a mask until arriving at L&D were they were issued one to wear (Line 154)? This was restated
6 - What was done with the newborns from a COVID-positive mother? Now addressed

Results
7 - 3 patients refused screening (line 178)?
They refused testing not screening and they were treated as PUIs
8 - Unclear what is meant by 'presumptive positive' (line 185) - were they symptomatic, or was the test equivocal?
This is described in the Methods section, it is considered positive but the PCR probe detects a different RNA sequence of the SARS-CoV 2
9 - Did Sinai have any policy about the number of allowed support persons during this interval? Line 187 states that 4 pts had a secondary support person - was this a second person in the room, or does this mean support person #1 tested positive and this person stepped in, instead?
Only one Support Person was permitted, the secondary Support Person was in lieu of the originally designated Support Person.

Discussion
10 - Unclear what is being said lines 218-222. Earlier it was stated all the support persons were asymptomatic, but here is said 'they were already symptomatic'?
This is now more clearly stated.
11 - The authors provide some general statements in paragraph lines 234-244, but what is Sinai doing? Do they have a separate unit for COVID-positive patients postpartum? What are they doing with the newborns? This is now included
12 - Also unclear what is being stated in lines 245-248. Sounds unnecessarily repetitive. Are they saying that if/when 'rapid/reliable' POC testing becomes available it would/could replace what they are doing now? It would be clearer to say this is the best strategy we have at the moment because we don't have such a test. This has been rephrased.
13 - The emphasis on anxiety (line 249) feels overdone. If patient and support both test negative, are they not wearing masks? Are the health care providers wearing masks in these rooms? A few weeks into the pandemic all persons began to wear masks.
The degree of anxiety among staff is extremely elevated. Our facility is outdated with small labor rooms, ORs and semiprivate postpartum rooms, the staff has felt extraordinarily fearful due to ongoing exposure regardless of mask use.
14 - What basis do the authors have for suggesting that universal testing 'may result in improved outcomes' (line 260)? This has been reworded

Figures
15 - Fig 1 does not seem necessary and could be shifted to Appendix or Supplementary Data will move to appendix
16 - Fig 2 also is not easy to understand and unnecessary to this reviewer
this has been removed

Tables
17 - This reviewer does not understand the value of Table 1 when 0 patients/support persons screened positive this has been removed
18 - Table 2 also is entirely provided in the text - and this seems repetitive this has been removed

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

lines 60-62: Should include include CIs for the prevalence rates among patients 15.5% (9.9-23.0%) and support persons 9.6% (5.2-16.1%)
This has been changed- we calculated the intervals using the normal approximation to the binomial and got similar intervals which we have added to the manuscript.

line 62 and Table 2, row labelled "Positive": The 11/19 and 8/19 fractions should be rounded to nearest integer %, not cited to 0.1% precision, due to the small denominator.
This has been changed

lines 65-68: Wouldn't a better characterization be to first state the rate of (+) COVID-19 and that all were asymptomatic in terms of the questionnaire used at the time and secondarily then report the rate of (+) among support persons? After all, all were asymptomatic.
This has been reworded
General: These women and their support persons were in hospital from April 4-15. Is there follow-up to determine whether the asymptomatic were actually pre-symptomatic, that is, did they subsequently develop symptoms?
Yes this will be published separately, over 80% remained asymptomatic

General: While the agreement between patients vs partners in terms of their COVID-19 test status was far from perfect, it was certainly not randomly allocated. By Fisher's test, the distribution is quite significant ($p < .0001$), while in terms of Kappa test for concordance, the value was $k = 0.63$ (95% CI = 0.42-0.83), which is classified in the moderate to good range for concordance. Again, it is not perfect, but it is also not discordant, in which the K value would be negative. Put another way, just looking at Fig 2, most patients who were (-) had partners who were (-), while among 19 (+), 8 had partners who were also (+), ie, clearly not a random allocation of test results. The CIs on the fraction 11/19 are quite wide, owing to the small sample, namely 58% (95% CI = 29-100%), making it difficult to generalize from these data that > 50% of partners of women who were (+) would be negative. Need more data to make a definitive statement re: rates of concordance for
patient/partner pairs.

We agree, it's clear that patient-partner status are strongly associated but not perfectly concordant. We also agree that our estimate that, 'among positive patients, ~50% of their partners test positive' is based on a small number of patients and additional data is needed to get a more precise estimate. Weve addressed this in our discussion.

~~JESSICA CAN YOU PLEASE ADDRESS THIS~~

Although a small number of (+), it would be informative to include a Table of age, parity etc for the 24 (+) vs the remaining 131 (-) women. Were there any important differences in terms of age, children in the home etc?
Will include→we have tentatively placed a table on the demographics of the positive patients, we will also include demographics on negative patients as a comparison but we are still collecting the data. We will update this in the next day or two for the complete data set.

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MANUSCRIPT EDITOR:

1. The title is quite long. I suggest changing it to, "Universal Testing of Patients and Their Support Persons for Coronavirus Disease 2019 (COVID-19) Prior to Scheduled Deliveries: Prevalence of Infection and Concordance and Discordance Rates."
This has been changed
2. The running title should be shortened to about 45 characters. If "COVID-19" is at the beginning of the running title, it will need to be spelled out.
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The appendix seems awfully small to make it an appendix. Can we make it a box?

Yes this is changed to a box

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59. You don't need to state this as it is in your methods. This has been removed

98. Please provide latest figures with revision This is now updated

136: please clarify. The symptom screen was on the phone. If they screened negative, did they have to come in the day before for NP Swab or was that done on admission? Do you know the test characteristics of your lab test? (FP, FN/Sens/Spec?)
Test characteristics now included. They came in the day before for testing
148: what was turn around time? This is now included

150: if the support person was designated as a PUI were they allowed to attend the birth? Yes and this is now stated

151: perhaps "birth partners" or "Labor support person" or something as 'partners" typically refers to relationship partners.This has been corrected

190: Unless there is a 3rd option for result (indeterminate?) you don't need to give both the positive and negative rate, as they should be inverse of each other. Noted and addressed

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

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es, we opt-in and you can include our responses to the revision letter

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Ok, this will be executed once the eCTA form is available for completion by authors.

3. All studies should follow the principles set forth in the Helsinki Declaration of 1975, as revised in 2013, and manuscripts should be approved by the necessary authority before submission. Applicable original research studies should be reviewed by an institutional review board (IRB) or ethics committee. This review should be documented in your cover letter as well in the Methods section of the body text, with an explanation if the study was considered exempt. If your research is based on a publicly available data set approved by your IRB for exemption, please provide documentation of this in your cover letter by submitting the URL of the IRB website outlining the exempt data sets or a letter from a representative of the IRB. In addition, insert a sentence in the Methods section stating that the study was approved or exempt from approval. In all cases, the complete name of the IRB should be provided in the manuscript.
The IRB approved this study and this is addressed in the cover letter and manuscript.

4. All submissions that are considered for potential publication are run through CrossCheck for originality. The following lines of text match too closely to previously published works.

Please cite lines 142-144 [A false negative…in the specimen]; our software shows that this is from Gnomegen's COVID-19 instructions for use.

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This was addressed in the manuscript (reference number 21)

5. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), observational studies using ICD-10 data (ie, RECORD), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at http://ong.editorialmanager.com. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, RECORD, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.
This is addressed and included with the manuscript

6. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.
Use of the revitalize definitons is not problematic in this manuscript

7. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.
The length restrictions have not been exceeded

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* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors,

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